POLICY QM 2.2 SHOWING REPORT

A. PURPOSE: To ensure a Quarterly Showing Report is received from each RBHA by the 10th day of the month following the end of each quarter.

B. SCOPE: ADHS/DBHS, Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (T/RBHAs).

C. POLICY: RBHAs shall submit a Quarterly Showing Report to ADHS/DBHS. The report shall demonstrate compliance with federal certification of need and re-certification of need requirements. ADHS/DBHS shall complete showing report requirements related to Tribal RBHAs. The Tribal RBHAs shall review and attest to the validity of the Quarterly Showing Report.

D. REFERENCES: 42 CFR 456.650 et. al.
AHCCCS/ADHS Contract
ADHS/RBHA Contract

E. PROCEDURES:

1. A "showing report" is a report that demonstrates compliance with federal requirements related to certification of need and re-certification of need for inpatient behavioral health services including inpatient hospitals, mental hospitals, residential treatment centers, and sub-acute facilities.

2. The RBHA shall:

   a. Complete the Quarterly Showing Report Certification form (Attachment A) including the signature of the RBHA's Medical Director or Chief Executive officer;

   b. Complete the Statistical Appendix Format (Attachment B); and

   c. Submit 2.a. and 2.b. above to the ADHS/DBHS Bureau of Quality Management and Evaluation by the 10th day of the month following the end of each quarter.

3. ADHS/DBHS shall:

   a. Check the accuracy of the information provided on the Statistical Appendix Format;

   b. Summarize the findings of the accuracy check for each RBHA in a table (Attachment C); and

   c. Submit the following documents to AHCCCS by the 17th day of the month following the end of each quarter:

      (1) A Showing Report Certification form from each RBHA (Attachment A),

      (2) A table summarizing the ADHS/DBHS findings concerning the accuracy of the RBHA information (Attachment C), and

      (3) A cover letter signed by the ADHS/DBHS Deputy Director or designee and the ADHS/DBHS Medical Director that includes the following information (Attachment D):

         (a) A certification that for the previous quarter, methods and procedures existed to ensure that federal requirements for certification of need and re-certification of need were met;

         (b) A statement that a certification submitted by each RBHA is attached to the cover letter;

         (c) A statement of the total number of TXIX records reviewed, the total number of errors determined by the ADHS/DBHS, and the overall error rate;

         (d) A statement of the total number of TXXI records reviewed, the total number of errors determined by the ADHS/DBHS, and the overall error rate;

         (e) If applicable, a statement that the ADHS/DBHS continues to investigate error reasons for quality improvement, and

(f) A statement identifying each RBHA that had no errors and the number of errors for TXIX and TXXI for each RBHA.

d. Provide feedback to each RBHA regarding the outcome of the ADHS/DBHS review of the information provided by the RBHA, including any recommendations or requirements for performance improvement actions.

F. APPROVED BY:

Leslie Schwalbe Date
Deputy Director
Arizona Department of Health Services
Division of Behavioral Health Services

Jerry L. Dennis, M.D. Date
Medical Director
Arizona Department of Health Services
Division of Behavioral Health Services

Attachment A

QUARTERLY SHOWING REPORT CERTIFICATION

CERTIFICATION

I hereby certify that during the calendar quarter of (Month and Year) through (Month and Year) for each eligible person for whom capitation for mental health services from AHCCCS was received, there were methods and procedures to assure that:

1. A qualified team certified (and, where inpatient services were furnished over a period of time, re-certified) the necessity of inpatient services for each eligible person receiving such services through (name of RBHA).

2. In the case of each (name of RBHA) eligible person receiving inpatient services, such services were furnished under a plan of care established and periodically reviewed and evaluated by a qualified team.

3. There was in operation a continuous program of utilization review under which the admission of each eligible person receiving services was reviewed or screened.

Date:_____ RBHA Name:_____

Typed Name	Title	Date

Signature	Title	Date

ATTACHMENT B

STATISTICAL APPENDIX FORMAT

(RBHA NAME) Statistical Appendix Report

For the period of _____ through _____

Check one: ? Title 19 ? Title 21

Date: _____ RBHA/GSA: _____

Last Name	First Name	AHCCCS ID	DOB	Initial CON	Recert 1	Recert 2	Recert 3

ATTACHMENT C

Showing Report Findings For the Quarter (Month/Year) through (Month/Year)

TXIX Number/Percent Errors

GSA or Tribal Contractor	# of Records	ID Error[1]	ID Error Rate	TXIX Eligibility Error[2]	TXIX Eligibility Error Rate	Combined Error Total	Combined Error Rate
03							
27							
26							
15							
23							
08							
Gila River							
Pascua Yaqui							
Navajo Nation							
Total							

[1] ID Error: Client does not match the PMMIS database in one of the following: last name, first name, date of birth, or AHCCCS ID.

[2] Title XIX Eligibility Error: Client is not Title XIX eligible on the date of the CON/RON as verified in the AHCCCS PMMIS database.

Last Revised: 08/01/2004

TXXI Number/Percent Errors

GSA or Tribal Contractor	# of Records	ID Error[1]	ID Error Rate	TXXI Eligibilty Error[2]	TXXI Eligibility Error Rate	Combined Error Total	Combined Error Rate
03							
27							
26							
15							
23							
08							
Gila River							
Pascua Yaqui							
Navajo Nation							
Total							

[1] ID Error: Client does not match the PMMIS database in one of the following: last name, first name, date of birth, or AHCCCS ID.

[2] Title XXI Eligibility Error: Client is not Title XXI eligible on the date of the CON/RON as verified in the AHCCCS PMMIS database.

Last Revised: 08/01/2004

ATTACHMENT D

[**DATE**]

[**TO AHCCCS Contact**]
AHCCCS
701 East Jefferson
2ND Floor
Mail Drop 6500
Phoenix, Arizona 85034

Re: Quarterly Showing Report

Dear [**AHCCCS Contact**]:

I hereby certify that during the calendar quarter [**Month and Year**] through [**Month and Year]**, for each eligible person for whom capitation for mental health services from AHCCCS was received, there were methods and procedures to assure that:

1. A qualified team certified (and, where inpatient services were furnished over a period of time, recertified) the necessity of inpatient services for each eligible person receiving such services through the RBHA/TRBHA.

2. In the case of each RBHA/TRBHA eligible person receiving inpatient services, such services were furnished under a plan of care established and periodically reviewed and evaluated by a qualified team.

3. There was in operation a continuous program of utilization review under which the admission of each eligible person receiving inpatient services was reviewed or screened.

Attached are the Showing Report findings submitted by the Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) for the quarter ending [**DATE**].

Letter to [**AHCCCS Contact**]
[**DATE**]

A total of [**NUMBER**] **TXIX** records contained [**NUMBER**] errors for an overall error rate of [**PERCENTAGE**]

A total of [**NUMBER**] **TXXI** records contained [**NUMBER**] errors for an overall error rate of [**PERCENTAGE**].

ADHS/DBHS continues to investigate error reasons for quality improvement.

[**RBHA(s)]** submitted an error-free Title XIX report this quarter.

[**RBHA(s)]** reported inpatient utilization for Title XXI members and both reports were [**ERROR RATE**].

If you have any questions, please contact the Bureau of Quality Management & Evaluation at (602) 364-4646.

Leslie Schwalbe Date
Deputy Director

Jerry Dennis, M.D. Date
Medical Director